

REFORMING HEALTH CARE WORKFORCE REGULATION

Policy Considerations for the 21st Century

Report of the
Taskforce on Health Care
Workforce Regulation

December 1995



Pew Health Professions Commission



Pew Health Professions Commission

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Suggested citation style: Finocchio L J, Dower C M, McMahon T, Gragnola C M and the Taskforce on Health Care Workforce Regulation. *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*. San Francisco, CA: Pew Health Professions Commission, December 1995.

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INTRODUCTION

*The desire to understand the world and the desire to reform it
are the two great engines of progress, without which
human society would stand still or retrogress.*
– Bertrand Russell

Our nation's health care delivery and financing structures are undergoing fundamental transformations. Market forces are shaping integrated delivery networks and dramatically increasing managed care enrollments, both of which are forcing greater cost constraints and practice accountability on providers. These transformations also are bringing increased emphases on primary care, prevention and population-based practice, interdisciplinary teamwork, and clinical effectiveness research.

These changes have highlighted the roles that America's 10.5 million health care practitioners play in the cost, quality, and accessibility of health care. Consequently, their education, training and distribution have received increased attention. Likewise, the current health care workforce regulatory system is under scrutiny.

Though it has served us well in the past, health care workforce regulation is out of step with today's health care needs and expectations. It is criticized for increasing costs, restricting managerial and professional flexibility, limiting access to care, and having an equivocal relationship to quality. The Federal Trade Commission reported in a study of the costs and benefits of occupational regulation that:

When properly designed and administered, occupational licensing can protect the public's health and safety by increasing the quality of professionals' services through mandatory entry requirements—such as education—and business practice restrictions—such as advertising restrictions. This report finds, however, that occupational licensure frequently increases prices and imposes substantial costs on consumers. At the same time, many occupational licensing restrictions do not appear to realize the goal of increasing the quality of professionals' services. While the majority of the evidence indicates that licensing proposals are often not in the consumers' best interest, we cannot conclude that the costs of licensing always exceed the benefits to consumers. In considering any licensing proposal, it is important to weigh carefully the likely costs against the prospective benefits on a case by case basis (Cox and Foster, 1990).

Health care workforce regulation has developed over the last century into fifty separate state systems creating a complex and often irrational organizational patchwork. The lack of uniformity in language, laws, and regulations between the states limits effective professional practice and mobility, confuses the public, and presents barriers to integrated delivery systems and the use of telemedicine and other emerging health technologies. These difficulties transcend state boundaries and call for standardization across the individual states. As Safriet (1994) writes:

Since health and illness are for the most part biologically and physically based, with some psychological and emotional components, it is not at all clear why licensure laws—that is, proxies for competency—should vary according to political boundaries rather than competency domains.

Current statutes grant broad, near-exclusive scopes of practice to a few professions and “carved-out” scopes for the remaining professions. These laws erect unreasonable barriers to high-quality and affordable care. The need for accessible health care calls for flexible scopes of practice that recognize the demonstrated competence of various practitioners to provide the same health services.

Perhaps most seriously, regulatory bodies are perceived as largely unaccountable to the public they serve. The public’s perception of professionalism and its need for information about practitioners has challenged the structure and function of professional boards. These realities call for improved accountability through increased public representation and disclosure of practitioner information so that consumers can make informed choices about their care.

Finally, recent reports and incidents have raised concerns that the regulatory system may not effectively protect the public. Continuing education requirements do not guarantee continuing competence. Additionally, the complaint process is often difficult for the consumer to initiate, and many complaints go without adequate investigation. Moreover, regulatory systems, in large part, have failed to implement mechanisms to evaluate their effectiveness and correct shortcomings. These problems call for effective continuing competence assessments and professional discipline processes, and a thoughtful evaluation of regulation’s effectiveness in protecting the public.

THE TASKFORCE ON HEALTH CARE WORKFORCE REGULATION

The Pew Health Professions Commission, recognizing that health care workforce reform must include regulatory reform, charged the Taskforce on Health Care Workforce Regulation to identify and explore how regulation protects the public’s health and to propose new approaches to health care workforce regulation to better serve the public’s interest.

The Taskforce began its work by discussing and articulating a set of principles for a health care workforce regulatory system. The Taskforce believes that regulation of the health care workforce will best serve the public’s interest by:

- *Promoting effective health outcomes and protecting the public from harm;*
- *Holding regulatory bodies accountable to the public;*
- *Respecting consumers’ rights to choose their health care providers from a range of safe options;*
- *Encouraging a flexible, rational and cost-effective health care system that allows effective working relationships among health care providers; and*
- *Facilitating professional and geographic mobility of competent providers.*

Though it has served us well in the past, health care workforce regulation is out of step with today’s health care needs and expectations.

The Taskforce explored many important issues related to health care workforce regulation and ultimately focused on ten. This report analyzes those ten issues as to why they do not meet the principles articulated for the regulatory system. The Taskforce makes **ten recommendations**, which appear at the beginning of each issue section, for improving the regulatory system.

With these recommendations, the Taskforce envisions a system for state regulation of the health care workforce for the 21st century that is *S.A.F.E.* :

- **Standardized** where appropriate;
- **Accountable** to the public;
- **Flexible** to support optimal access to a safe and competent health care workforce; and
- **Effective** and **Efficient** in protecting and promoting the public's health, safety, and welfare.

For each issue, **innovations and other approaches** to improve the problem were explored. This report details the **challenges for the 21st century** that must be faced by state legislatures, professional boards, consumers and the health care professional and provider communities as they endeavor to improve each issue addressed. Finally, the **related topics for discussion** at the end of each issue section were recognized as important by the Taskforce but beyond the scope and resources of this report.

The Pew Health Professions Commission endorses the need to reform the regulatory system, the general vision articulated by the Taskforce on the future of the system, and the invitation to an ongoing discussion of the ten recommendations proposed to achieve this vision. The Commission believes that state legislatures, professional boards, consumers and the health care professional and provider communities should engage in a broad discussion of the policy actions needed to improve health professional regulation in the 21st century. Consequently, it offers **policy options for state consideration** under each recommendation as a way of stimulating debate and discussion on each of the issues.

The issues discussed, innovations explored, challenges proposed, recommendations and policy options offered in this report, are made in general about health care workforce regulation. In some states and for some professions, particular issues may be more serious and future challenges more ominous. In other states and for other professions, however, certain issues may not be relevant or significant progress already made.

Given the scope and complexity of these issues and recommendations, it is impossible to acknowledge every nuance of an issue, every innovation made by a state or profession, or every political reality necessary for reform. It is the Commission's intention that this report will stimulate extensive debate and discussion so that each nuance, innovation and political reality is illuminated, criticized or complimented, and widely discussed.

SUMMARY OF THE TEN RECOMMENDATIONS

RECOMMENDATION 1 States should use standardized and understandable language for health professions regulation and its functions to clearly describe them for consumers, provider organizations, businesses, and the professions.

RECOMMENDATION 2 States should standardize entry-to-practice requirements and limit them to competence assessments for health professions to facilitate the physical and professional mobility of the health professions.

RECOMMENDATION 3 States should base practice acts on demonstrated initial and continuing competence. This process must allow and expect different professions to share overlapping scopes of practice. States should explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills.

RECOMMENDATION 4 States should redesign health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing health care delivery system.

RECOMMENDATION 5 Boards should educate consumers to assist them in obtaining the information necessary to make decisions about practitioners and to improve the board's public accountability.

RECOMMENDATION 6 Boards should cooperate with other public and private organizations in collecting data on regulated health professions to support effective workforce planning.

RECOMMENDATION 7 States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.

RECOMMENDATION 8 States should maintain a fair, cost-effective and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health.

RECOMMENDATION 9 States should develop evaluation tools that assess the objectives, successes and shortcomings of their regulatory systems and bodies to best protect and promote the public's health.

RECOMMENDATION 10 States should understand the links, overlaps and conflicts between their health care workforce regulatory systems and other systems which affect the education, regulation and practice of health care practitioners and work to develop partnerships to streamline regulatory structures and processes.

1

STANDARDIZING REGULATORY TERMS

Adopting uniform health professions regulatory language for the public and the professions.

RECOMMENDATION

States should use standardized and understandable language for health professions regulation and its functions to clearly describe them for consumers, provider organizations, businesses, and the professions.

Policy options for state consideration:

- Use the term “licensure” for public or state regulation of health professions title protection and practice acts.
- Use standard language in health professional licensing statutes including reference to:
 - title protection;
 - practice acts;
 - regulatory terms such as “supervision” and “delegation;” and
 - enforcement and discipline processes and outcomes, including uniform definitions of classes of alleged offenses, and phases in and outcomes of the adjudication process.

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Confucius was once asked by a prince to take charge of government. An observer asked what Confucius’ first reform would be. Confucius said, “I would begin by defining terms and making them exact.” The observer was puzzled. “How can you possibly put things straight by such a roundabout route?” Confucius answered, “If terms are not correctly defined, words will not harmonize with things. If words do not harmonize with things, public business remains undone, order and harmony will not flourish, and the people will be unable to move hand or foot.”

THE ISSUE

Because professional regulation has developed separately in each state, the terms used to describe levels and functions of regulation vary from state to state and from profession to profession. The lack of uniformity in language among the states and the professions limits effective professional practice and mobility, creates barriers to high quality health care, and confuses regulators, legislators, professionals, and the public.

Much of the confusion is due to misuse of the terms “licensure,” “certification” and “registration” when referring to different tiers of regulation. For example, according to statutory definition, Registered Nurses (RNs) are licensed, not registered. Certified Registered Nurse Anesthetists are licensed RNs who have been certified by the Council on Certification of Nurse Anesthetists, a private credentialing organization. The confusion is magnified when non-health professions are considered: under common definition, certified public accountants are licensed, not certified. Below is a brief

**Policy options for
state consideration:**

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- Reserve the term “certification” for voluntary private sector programs that attest to the competency of individual health professionals.
- Identify and convene a body to codify regulatory terms and language. States should consider models for standardizing and adopting terms such as those employed by the National Conference of State Legislatures, the National Governors’ Association, or the Council on Licensure, Enforcement and Regulation. This body should include representation from the regulated health professions, consumers, providers, and payers of health care.

glossary of the current, commonly accepted definitions of types of state regulation:

Professional “licensure” refers to permission granted by government to engage in a business or occupation or in an activity otherwise unlawful. With licensure, the government asserts that the licensee has met minimum standards of qualification to ensure that the public health, safety, and welfare will be reasonably protected. This most common form of health professional regulation confers a state-protected practice act (“scope of practice”) authorizing a specific occupation or profession to provide specific services (♦ *See Issue 3 – Removing Barriers to the Full Use of Competent Health Professionals*). Practice acts can be exclusive and monopolistic (especially for the early-established professions such as medicine), a carved-out section of another profession’s scope of practice, or a combination of various portions of other professions’ scopes of practice.

State “certification” regulates the use of a specific occupational title (e.g., “certified nurse assistant,” or “certified occupational therapist”), but does not provide a service monopoly; anyone may deliver the service, but only those actually certified may use a protected title. State certification makes it illegal for a person to use the title of the profession without certification (or “license,” an example of the confusion in the use of terms). The reserving of professional titles for those meeting certain

state standards is sometimes called “right-to-title” legislation. More often, these acts are referred to as state “certification” — a term very often confused with certification by private organizations.

State “registration” is generally a matter of registering (by name, address, and qualifications) with a state authority, without necessarily meeting standards for entry-to-practice or continued competence.

As demonstrated above, the single word “certification” may mean several different things in different situations. State certification is a public function that protects a profession’s title. In contrast, private certification — usually by private specialty associations or boards — identifies practitioners who have met the standards of the private organization. Adding a third layer of confusion are “certificates” awarded to graduates of graduate schools, community colleges, and vocational schools that only

indicate completion of a specific program. In addition, health facilities may be “Medicare certified.” Anyone or any organization can “certify” or attest to standards met. Complicating the matter further is the term “credential” which is not usually defined in statute but is widely used by professionals, the public, regulators and legislators as evidence (public or private) of someone’s qualifications.

Terms for regulatory mechanisms such as scopes of practice and disciplinary processes also vary by state and by profession. Because of these variations, states may encounter difficulty when discussing regulatory functions or procedures with other states. For instance, a letter of reprimand can be a disciplinary action in one state and a non-disciplinary action in another state. Confusing the two could have grave consequences.

Few legislators, regulators, professionals, or consumers understand the differences and distinctions in statutory and regulatory language, but many realize the problems inherent in inconsistent terminology. States have difficulty implementing mutual recognition or endorsement licensure policies with each other (♦ See Issue 2 – *Standardizing Entry-to-Practice Requirements*). And professionals have a difficult time explaining their qualifications and competencies to health care employers. The misuse or misinterpretation of regulatory terms underlines the often meaningless distinctions among regulatory categories. In our expanding global communities, inconsistent terminology inhibits the effectiveness and accountability of regulatory processes because neither consumers nor professionals understand it.

INNOVATIONS AND OTHER APPROACHES

Although many states recognize the implications of using non-standard terms for regulatory functions within and across states, few states have enacted standards for regulatory language. Leading a promising trend, Montana recently adopted a Uniform Licensing Act, which establishes uniform guidelines for the licensing and regulation of professions and occupations under the jurisdiction of professional and occupational licensing boards (Montana Department of Commerce, 1995). The act covers all professional and occupational licensing boards in the state’s Department of Commerce — both health related and technical — and includes provisions for board authority, licensure procedures, complaint investigations, and sanction procedures and policies. While standardized language within individual states is an important first step, standardization would be even more effective if it were incorporated in every state for the regulation and licensure of all health professions.

While most states have declined so far to adopt uniform language or terminology for health professions regulation, various private organizations have taken the lead. Several national associations of professional regulatory boards have proposed uniform language models, as has the Council on Licensure, Enforcement and Regulation (CLEAR, 1995). States might look to these models when considering standardized statutory and regulatory language.

The lack of uniformity in language among the states and the professions limits effective professional practice and mobility, creates barriers to high quality health care, and confuses regulators, legislators, professionals, and the public.

CHALLENGES FOR THE 21ST CENTURY

The U.S. health care system is changing dramatically; states have an opportunity to facilitate and control some of these changes by using regulatory terminology properly. Because the vast majority of state health professional regulation is in effect “licensure” (establishing minimum standards, practice acts, and sanctioning mechanisms for violations), state legislators should use the term “licensure” to refer to any regulation of practice acts and title protection. States should decline to use the term “certification,” leaving it to the exclusive use of private sector credentialing bodies.

The non-uniformity of language transcends state boundaries and calls for standardization across the country. States will be challenged to use uniform and understandable language for health professions regulation and its functions to clearly describe them for consumers, provider organizations, businesses, and professions. Such a system would foster greater understanding of regulatory functions by both the public and the professions. This unanimity of understanding consequently would improve system accountability and effectiveness.

RELATED TOPICS FOR DISCUSSION

- International trade agreements and standardized terms
- Elimination of “registration” as a state regulatory term

2

STANDARDIZING ENTRY-TO-PRACTICE REQUIREMENTS

Facilitating the physical and professional mobility of the health professions.

RECOMMENDATION

States should standardize entry-to-practice requirements and limit them to competence assessments for health professions to facilitate the physical and professional mobility of the health professions.

Policy options for state consideration:

- Adopt entry-to-practice standards which are uniform throughout the fifty states for each profession.
- Adopt mutual recognition of licensure by endorsement legislation, even without uniform entry-to-practice standards.
- Cooperate with the relevant private sector organizations and with other states to develop and use standard competency examinations to test minimum competence for entry-to-practice. In developing these standards, states should resist reliance on accreditation or examination

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For 20 years, a Swedish trained physical therapist obtained a license from and practiced with an unblemished record in two states and one Canadian province. When she moved to a third state, where entry-to-practice requirements called for a certain number of academic hours in specific fields, she was missing six “general education” hours (not related to physical therapy) and was denied a license. No credit was given for 20 years of excellent practice and an apparently equivalent education.

THE ISSUE

Legislators and regulators, in setting entry-to-practice requirements, must balance competing goals of respecting constitutional freedoms and protecting the public's health, safety, and welfare. In most instances, well-respected standards exist that require graduation from an accredited educational program, completion of an internship, residency or supervised apprenticeship, the successful completion of an examination, and in some cases, a personal character review.

Despite the narrowly tailored nature of entry-to-practice requirements, criticism has mounted regarding their overall effect on the health care system (Furrow et. al., 1995; Safriet, 1992). Three critical problems have been identified: 1) the lack of uniformity in entry-to-practice requirements among the states limits effective professional practice and mobility; 2) current entry-to-practice standards are not limited to competence; and 3) the processes and systems for entry-to-practice development are not accountable to the public.

The lack of standardization among the 50 states' entry-to-practice requirements creates unreasonable barriers to interstate mobility for many professionals. With integrated health care

**Policy options for
state consideration:**

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- standards which do not directly and demonstrably relate to the minimum knowledge and skills necessary for safe and contemporary practice.
- Recognize alternative pathways in education, previous experience, and combinations of these, to satisfy some entry-to-practice requirements for licensure.
- Eliminate entry-to-practice standards which are not based on the competence, skills, training or knowledge of the professional.

delivery systems and telemedicine crossing state boundaries (Intergovernmental Health Policy Project, 1995), workforce downsizing and dislocation, and the increasing mobility of the population, rigid and inconsistent entry-to-practice requirements restrict the rational and effective use of our health care workforce. Dentistry's entry-to-practice requirements, for example, have been characterized as anti-competitive measures that erect barriers to mobility, and contribute to the high cost and inadequate accessibility of care (Altschuler, 1994). State-by-state differences make it difficult for professionals to practice when they move to another state. Friedland and Valachovic (1991) have even suggested that the public has been led to believe that ensuring an acceptable standard of care is incompatible with allowing practitioners the freedom to move from state to state. These variations also limit consumers' access and raise costs.

The effectiveness of current entry-to-practice standards is compromised when they are not based solely on competence. A requirement, for example, regarding place of residence, which goes beyond assessing the competence, skills, training, or knowledge of the professional, should be eliminated. Additionally, state waivers for entry requirements that belie the "protect the public" justifications call for review and reform to ensure that entry-to-practice requirements are

based on competence. Colorado waives licensing requirements for out-of-state physicians practicing with Olympic athletes. Maine does the same for camp physicians. South Carolina does it for volunteer physicians practicing in a clinic for low-income and uninsured patients. No one submits that young campers, athletes, or residents of some areas should receive less regulatory protection than others; the waivers are accorded to competent practitioners who practice within strict parameters of quality established in another state.

In addition, rigid requirements for education and training from an accredited institution ignore comparable or innovative education, training, and work experience. For example, a professional who has practiced for years and pursued an education equivalent to accreditation requirements often cannot meet entry-to-practice requirements. This hampers professional mobility within a profession and between related professions.

Finally, entry-to-practice standards, by having an unreasonably strong link to professional associations, fail to account fully to the public. States have delegated virtually all their authority for setting entry-to-practice standards to accreditors and professional associations (♦ *See Issue 10 – Understanding the Organizational Context of Health Professions Regulation*). The public, other professions, and employers

have not participated in developing examinations and establishing accreditation standards. Any uncritical reliance on professional associations alone in establishing the education, training and testing requirements for entry-to-practice raises questions of accountability and effectiveness.

INNOVATIONS AND OTHER APPROACHES

Medicine and nursing have made admirable efforts to standardize entry-to-practice requirements. In addition to adopting uniform testing instruments, states can look to various national professional associations for model entry-to-practice standards and other regulations. A 1994 resolution of the American Medical Association which called for a national medical license limited to telemedicine consultation was not adopted. However, the Federation of State Medical Boards suggests that its existence indicates a portion of the medical community sees benefit in national licensure programs (Winn, 1995).

States also have explored the possibility of requiring private (i.e., non-state) credentialing to address current state entry-to-practice problems. The American Nurses Association, for example, uniformly certifies nurse practitioners (NPs) in all 50 states. While this ensures uniformity and standardization, problems exist in deferring certification to professional associations. Notably, ANA certification requires a master's degree in some instances, though there are no data showing that a master's degree is necessary for competence as a nurse practitioner. "A master's degree requirement may not serve the public needs (e.g., decreased NP supply, higher salary for master's-prepared NPs) as much as it may serve the professional organization's needs" (Hall, 1993).

The lack of uniformity in entry-to-practice requirements among the states limits effective professional practice and mobility.

In other areas, dentistry has explored the concept of national licensure and challenged entry-to-practice restriction based on constitutional rights and the freedom to move, without discrimination, between the states (Altschuler, 1994). By recognizing the problem but declining to enact statutes that mirror those of other states, some states have adopted "licensure by endorsement" policies that recognize the license of a practitioner from another state.

Looking beyond the health professions, one can find further innovative approaches to entry-to-practice standards. For example, the Federal Aviation Administration requires commercial pilots to be tested for specific competency to fly particular planes. In California, applicants to practice law may sit for the state bar exam even if they have not graduated from an accredited law school. If they pass, they can be licensed to practice. These examples point out that entry-to-practice standards need not be as "accreditation-dependent" as they currently are in health professions regulation.

CHALLENGES FOR THE 21ST CENTURY

Efforts to standardize entry-to-practice requirements and adopt licensure-by-endorsement policies indicate progress. The challenges for legislators and regulators will be to 1) adopt standards that are in

the interest of the public rather than the interest of the profession or professional association proposing them, and 2) to avoid resorting to the “lowest common denominator” when agreeing to uniform standards across the country.

The lack of uniformity in laws and regulations among the states limits effective professional practice and mobility, confuses the public, and presents barriers to integrated delivery systems and the use of telemedicine and other emerging health technologies. The standardization of entry-to-practice requirements limited to competence assessments for health professions would facilitate the physical and professional mobility of the health professions and improve the accessibility of health care services. Furthermore, reformed entry-to-practice standards not so closely linked with the accreditation process would permit greater flexibility and accountability to the public.

RELATED TOPICS FOR DISCUSSION

- Accountability of the accreditation process
- Information technology and standardized competency testing
- Personal character assessments as entry requirements

3

REMOVING BARRIERS TO THE FULL USE OF COMPETENT HEALTH PROFESSIONALS

Improving the public's access to a competent and effective health care workforce.

RECOMMENDATION

States should base practice acts on demonstrated initial and continuing competence. This process must allow and expect different professions to share overlapping scopes of practice. States should explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills.

Policy options for state consideration:

- Eliminate exclusive scopes of practice which unnecessarily restrict other professions from providing competent, effective and accessible care. States should ensure that the training, testing and regulating of health professionals allow different professions to provide the same services when competence — based on knowledge, training, experience and skills — has been demonstrated.

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In Washington state, dental hygienists can independently contract to clean the teeth of elderly persons in long-term care facilities. In Colorado, dental hygienists can contract to clean teeth in any setting without a dentist's "treatment plan" or supervision. In most other states, dental hygienists can only clean teeth under the direction or supervision of a dentist. To protect the public from harm, is it necessary to prohibit dental hygienists from cleaning teeth without supervision?

THE ISSUE

"Scopes of practice," describe the authority vested by a state in health professionals who practice in that state. They draw the boundary between the lay person and the professional; the non-health professional who provides medical services is "practicing medicine without a license." Scopes of practice also draw the boundaries among the professions, creating exclusive domains of control over the delivery of specific services. Many professions argue that this exclusivity denies them the right to provide services they are competent to render (Safriet, 1994). The result has been a flood of "border wars" or "turf battles" between professions.

Written into statute by state legislators, implemented in state regulations, and interpreted by state courts, practice acts vary tremendously by profession and by state. Some are very broad; others quite narrow. For example, states accord physicians a broad scope for the practice of medicine, including diagnosis and treatment of ailments. Other health professions are either allowed a small portion of that broad scope or delegated the authority to perform certain procedures. Some professions, such as

**Policy options for
state consideration:**

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- Grant title protection without accompanying scope of practice acts to some professions. This would be appropriate for professions (e.g., massage therapy) which provide services which are not especially risky to consumers. Consumers will benefit from the assurance that the titled professional has met the state's minimum standards for initial and continuing competence.
- Allow individual professionals from one profession to expand their scopes of practice with an additional service or level of service found in one or more other professional practice acts through a combination of training, experience and successful demonstration of competency in that skill or service level.

nursing, have ended up with statutory language so vague that it is sometimes difficult to recognize a legally significant practice act (Hall, 1993).

The varying objectives and levels of specificity found in different professions' scopes of practice are more than frustrating; they have encouraged a system that treats practice acts as rewards for the professions rather than as rational mechanisms for cost-effective, high quality and accessible service delivery by competent practitioners. Although couched in consumer protection language, scopes of practice are not always based on the demonstrated ability to provide services that are potentially harmful if not performed competently. Rather, they are written to define differences among professions. Scope of practice battles have come to resemble contests for more patients, more status and power, more independence, and more money.

For scopes of practice to effectively protect the public's health, legislators who craft them must balance the competing interests of quality, cost, and access. Because quality of services rendered is nearly impossible to guarantee, states use measures of minimum competence, followed by disciplinary enforcement, to serve as proxies. Current scopes of practice, however, are not restricted to competence. Despite one profession's demonstration of competence to provide services — by clinical outcome studies, education, testing, and training — this same profession must also engage in political battles with other professions authorized to provide those services. Additionally, critics contend that present regulations not only restrict the practice of non-physician practitioners beyond what is justified by skills and training, but grant practice authority to physicians beyond their actual competence (Weed and Weed, 1994).

Geographic and title-based scope of practice regulation cannot meet the challenges of interstate provision of health care through telecommunications and sophisticated software programs that may allow other practitioners to perform services now reserved by law for physicians (Weed and Weed, 1994). The inflexibility disregards the competence of other professions to provide the same or similar services safely (Office of Technology Assessment, 1986; Begun and Lippincott, 1993). It extends to individual careers when health professionals are barred from developing skills they could incorporate competently into their practices. Further, when licensure and scopes of practice are considered desirable and legitimizing — but ultimately difficult to achieve — the development of new professions is stymied.

Beyond this inflexibility, the inefficiencies of our regulatory system result in increased costs. Economists view licensure laws as state-enforced service monopolies that decrease competition, increase costs, and decrease access for the consumer, with the most restrictive licensure statutes contributing the most economic harm to the consumer (Hall, 1993). Health care delivery organizations have recognized that increased costs can be attributed in part to the limited number of professions who can competently provide the same care less expensively (Nichols, 1992).

The cost of services is also increased by professional turf battles. As is evident today in professional journals, at professional meetings, and in state legislative offices across the country, many professions are investing significant amounts of time and money to garner legislative support for new or broader scopes of practice. The professions with established scopes of practice are spending comparable, if not more, resources defending their scopes from threats of invasion.

INNOVATIONS AND OTHER APPROACHES

Recent attempts to mold the regulatory system to function more rationally and effectively have included expanded scopes of practice, delegation and supervision stipulations, and practice act waivers. They result from inter-professional legislative battles and personnel shortages in underserved areas, and they do not achieve the broad flexibility needed to improve access and lower costs while maintaining or improving quality.

In 1994, 135 laws — more than one-third of the 400 proposed — were enacted to expand scopes of practice for various practitioners around the country (Intergovernmental Health Policy Project — Scopes of Practice, 1994). After hard-won battles, some health care services (e.g., prescribing medications and practicing independently) — long the preserve of doctors — have been opened up to other professionals. These include nurse practitioners, physician assistants, optometrists, podiatrists, midwives, and audiologists (Rogers, 1994; Intergovernmental Health Policy Project, 1995).

Some states and institutions are also revisiting delegation and supervisory rules. Under current delegation laws and interpretations, a practitioner may delegate tasks or services within his or her scope of practice to someone who would not otherwise be allowed by law to perform them. Practitioners who currently require delegation or supervision are attempting to gain more independent authority to perform services. While some services, such as prescriptive authority, were previously delegated to advanced practice nurses (APNs) by physicians, APNs have adapted their education, training and entry-to-practice standards to ensure competence in performing those services independently.

This scenario is being played out between other professions, such as dentists and dental hygienists. These scope of practice transformations are difficult as the various health professions are not always fully knowledgeable about or accepting of the others' education, training, competence, or regulation. Professional competition and turf battles exacerbate these issues.

Finally, many states waive scope of practice requirements and grant different practice acts to some of their licensees; for example, nurse practitioners providing care in underserved rural or inner city areas

We have a system that treats practice acts as rewards for the professions rather than as rational mechanisms for cost-effective, high quality and accessible service delivery by competent practitioners.

sometimes have broader scopes of practice than their colleagues in more competitive markets (Safriet, 1994). Safriet points out that a regulatory system that attempts to differentiate between an earache in one location from an earache in another makes no sense and calls for reform.

Other, non-state regulatory activity that affects scopes of practice include discussions of “institutional licensure” (shifting regulatory and public protection responsibility from the states to hospitals, HMOs, and integrated delivery systems) and third party restrictions on groups of practitioners eligible for reimbursement (♦ *See Issue 10 – Understanding the Organizational Context of Health Professions Regulation*).

The problems inherent in transferring this type of regulatory responsibility or authority from the state to the private sector are myriad: the incentives are dramatically different (protecting the public vs. turning a profit), as are the types of malpractice liability and contractual relationships with the practitioners; practitioner mobility is potentially limited outside the institution; and evaluating practitioner competence is difficult. Institutional licensure is fraught with disagreements and concerns and must be fully confronted and debated by professionals and regulators as they critique and reform health professions regulation.

Other, non-state regulatory innovations include Indian Health Services, an agency in the U.S. Department of Health and Human Services, which has developed a unique and successful program in Alaska that goes beyond the traditional limits of scopes of practice by basing practice authority on competence and performance ability. Community Health Aides (CHAs), after meeting standards for training, certification and continuing education, collaborate by phone or radio with physicians to provide emergency, preventive, and primary care. Not licensed or certified by the state, the typical CHA is a 38-year old Native woman with four children, an 11th grade education, and 7 years’ experience as a CHA. The program has played “a major role in improving the health status of Alaska Natives;” in 1991, CHAS served about 45,000 Alaska Natives and handled more than 253,000 patient encounters (Government Accounting Office, 1993).

The province of Ontario, Canada has taken another approach to reshaping scopes of practice. Over a ten-year period — completely separate from national insurance reform efforts — provincial leaders reworked the regulatory system to make it more flexible and accountable to the public (Bohnen, 1994). In a novel treatment of scopes of practice that does not grant monopoly status to various professions, the new Ontario law identifies thirteen “controlled acts” that are potentially dangerous to the public. The 24 companion laws that cover the regulated professions each contain 1) individual “scopes of practice” that describe the profession in general terms and 2) “authorized acts” listing the controlled acts that may be performed by a member of that profession.

For example, the Medicine Act grants physicians the authority to perform 12 of the 13 controlled acts under their practice act. Under the Midwifery Act, midwives are authorized to perform seven acts including managing labor and conducting spontaneous normal vaginal deliveries. Massage therapists, although regulated, may not perform any of the 13 controlled acts under the Massage Therapy Act. Ontario's regulatory reform efforts, effective January 1994, are being closely watched to see how well provincial regulators have separated professional titles from exclusionary scopes of practice and slowed turf battles.

CHALLENGES FOR THE 21ST CENTURY

Though many scope of practice developments point to promising trends, they may not be comprehensive, sufficient, or appropriate enough to meet the regulatory needs of the public. State-by-state and profession-by-profession revisions to scopes of practice, delegation and supervision rules, waivers, and exceptions may only exacerbate the lack of standardization. This reinforces a piecemeal approach to regulation that encourages isolation and separatism among health professionals and among states.

Progressive changes made to scopes of practice would be most effective if they were implemented across all 50 states. Moreover, broad-based changes should affect each licensee that shares that scope of practice. In the event that states move to recognize scope of practice changes for individual professionals, the expanded scope would best serve the practitioner and the public if it were portable to all workplaces and states.

United States health care consumers need a regulatory system that bases authority to practice on the practitioner's demonstrated initial and continuing competence (♦ *See Issue 2 and Issue 7 – Standardizing Entry-to-Practice Requirements and Assuring Practitioner Competence*) — acknowledging that differently trained and differently named professions may deliver the same services — so long as they demonstrate competence. Professionals should be allowed and encouraged to provide services to the full extent of their current training, experience and skills. A regulatory system that maintains its priority of quality care, while eliminating irrational monopolies and restrictive scopes of practice would not only allow practitioners to offer the health services they are competent to deliver, but would be more flexible, efficient, and effective.

RELATED TOPICS FOR DISCUSSION

- Limited licenses
- Multi-skilling and regulation
- Delegation and supervision
- Competence testing
- Reimbursement
- Independent practice and malpractice liability coverage

4

REDESIGNING BOARD STRUCTURE AND FUNCTION

Responding to the changing expectations of the public and the health care delivery system.

RECOMMENDATION

States should redesign health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing health care delivery system.

Policy options for state consideration:

- Establish an interdisciplinary oversight board which has a majority of public members. The mission of this board should be to coordinate health professions regulation to meet an explicit state health policy agenda and provide oversight to ensure that the public's best interests are served. This board should have the authority to approve, amend or reject decisions made by individual boards.
- Consolidate the structure and function of boards around related health professional or health service areas. These consolidated boards should be dedicated to consumer protection and quality
(continued on next page)

State medical boards are charged with protecting the public interest. For many years, only physicians served on medical boards. Those board members had the responsibility to oversee the actions of other physicians, monitoring ethical obligations to the public. But with the growth of consumerism, public members were added to medical boards. The consumer movement not only brings a public perspective to boards but also rejects the paternalism of physicians' decision making. Paternalism in medicine said, "We know what is best for you." Consumerism says "Give me the information and allow me to make my own choices."

—Chandler, 1995

THE ISSUE

The regulatory infrastructure — including board organization and composition, administrative processes, and funding — is increasingly unable to support an accountable, effective and efficient regulatory system (Yessian, 1994). This may be due in part to its unique form. Like other administrative agencies, professional boards command executive, legislative and judicial powers. What makes them different from all other types of administrative bodies is that the board members who set policy are not full-time government employees, but rather individuals who, for the most part, are members of the profession they are empowered to regulate.

This combination of self-regulation with the authority of the state has generated concerns. The considerable autonomy and independence with which professional boards regulate their respective profession has led to criticisms that professional self-interest, and conflict of interests, are inherent in self-regulation (Cohen, 1980). The structure has also prompted public demands for more accountability and openness out of fear that

**Policy options for
state consideration:**

(continued from previous page)

assurance. Such consolidated boards, for example, might be medical/nursing care, vision health care, oral health care, rehabilitation, mental health care or health technologies.

- Develop board membership profiles that include significant, meaningful and effective public representation to improve board credibility and accountability. States should evaluate the board member appointment process to ensure that all appointments are fair and accountable to the public. All board members should be carefully recruited, well-trained and supported.
- Staff and finance all boards and regulatory committees so that they can perform their missions effectively and efficiently. Support should include funding for appropriate technological needs.
- Compose boards with representatives of the state's urban, rural, ethnic and cultural communities. Boards should also include representatives from the health care delivery system.

professional self-interest eclipses public protection as board priorities (Yessian, 1992; Rockwell, 1993).

Many states have addressed this concern by adding public members to boards but debates about their appointment, purpose and effectiveness remain. Opposition to public members comes from professional members who claim that board issues are often beyond the technical abilities of a public member. Public members are appointed precisely because they are not members of the profession. Public members are supposed to challenge and complement board decision-making from a critical, non-professional perspective; they are the "social conscience" of a board (Rockwell, 1993).

It is one thing to subscribe to the concept of public representation. It is another to assume that public representatives are effective. Complex yet crucial to the success of regulation in the public interest, effective public participation has been challenging for three reasons: 1) the identification and selection process has been flawed; 2) public member roles and responsibilities have been unclear; and 3) training and support for public members has been inadequate or nonexistent (Citizen Advocacy Center — Public Representation, 1995). These problems must be overcome if public participation is to fulfill its promise.

When communication between boards, and representation of all relevant perspectives are lacking, boards cannot be effective. Despite their common legislative mandates, individual boards seldom work together to coordinate their efforts. Given the increasingly interdisciplinary and patient-centered nature of care delivery, this lack of cooperation and policy coordination perpetuates isolation and protectionism, further fragmenting quality assurance and public protection.

Additionally, since many of the broad policy issues facing professional boards relate to cost, quality, and accessibility of health care, the perspective and experience of other professionals, consumers, employers and state health departments would provide useful knowledge and insight. Boards, however, are not generally constituted to reflect demographic distributions or interested party representation.

Finally, effective regulation demands adequate funding and support. Reduced government budgets have resulted in diminished resources and increased responsibilities and case loads.

INNOVATIONS AND OTHER APPROACHES

After decades of debate, a majority of states and professions have experimented with public or “other” profession members on their health professions boards (Colorado Department of Regulatory Agencies, 1994), and public members are now the rule rather than the exception (Yessian, 1994). Public membership has democratized professional regulation. Some states have taken particularly strong leads in reforming professional board composition; almost half (46%) of the members of Rhode Island’s medical board are from the public.

In addition to various states’ experimentation, oversight coordination and public participation are now key to health professions regulation in Ontario, Canada (Bohnen, 1994). The province’s Health Professions Regulatory Advisory Council, independent of the professional “colleges” (self-regulating professional bodies) and the Ministry of Health, is comprised entirely of “public” members (i.e., people who are neither government employees nor part of the regulated profession). This Council advises the Minister of Health on regulation or de-regulation of specific professions, amendments to acts and regulations, quality assurance programs undertaken by the colleges, and evaluation of the colleges’ patient relations programs. Ontario’s Council thus addresses the twin goals of increased effectiveness through oversight and accountability through public participation.

Public members are supposed to challenge and complement board decision-making from a critical, non-professional perspective; they are the “social conscience” of a board.

In the United States, the General Assembly of the Commonwealth of Virginia established the Board of Health Professions in 1977 to advise the governor and the Assembly on matters related to health occupational and professional regulation. Most importantly, this board is charged with providing overall policy coordination for the twelve health professional regulatory boards. The board is comprised of seventeen members appointed by the governor. One member is appointed from the membership of each of the twelve health professional regulatory boards, and five are citizen members (Virginia Department of Health Professions, 1992).

In Maine, a 1995 report to the governor and Legislature recommends the establishment of a federation of health professions boards which would address inter-professional issues and relationships, and improve overall regulatory policy coordination and communication (Maine Health Professions Regulation Taskforce, 1995). The federation and its commissioner would be responsible for crafting and coordinating regulatory “system” policy to remedy the current fragmented policy making which focuses on individual professions. Proposals for

such inter-professional oversight boards are not, however, new; several reports in the 1970s advocated their establishment (Cohen, 1980).

Regulatory reform proposals have also advocated for boards representing clusters of related professions, such as vision care and oral health care. After 1992-93 Sunset Review Commission hearings, Texas merged the administrative functions of its physical and occupational therapy boards into one Executive Council. The objectives of the council, composed of one professional and one public member of each board plus one non-board public member, are to streamline functions such as the issuance and renewal of licenses, and to provide overall policy coordination and accountability. The new statute maintains individual physical and occupational therapy boards, but grants the council the authority to evaluate the boards and to review rules they submit for publication in the Texas register (Texas Civil Statute, 1993). As a result of the same sunset commission, the Texas legislature also created the Health Professions Council to coordinate the administrative and regulatory efforts of all health care licensing boards (Texas SB 674, 1993).

CHALLENGES FOR THE 21ST CENTURY

The public's perception of professionalism combined with marketplace changes have challenged the structure and function of professional boards. These realities call for improved accountability through increased public and interdisciplinary representation, oversight and coordinated efforts among the various professional boards, and adequate funding and support for regulatory boards to successfully accomplish their goals and objectives related to public protection. For oversight boards to effectively coordinate regulatory policy in the public's interest, they will require considerable power and authority to shape the actions taken by individual boards.

As health care services increasingly reflect a "continuum of care" rather than discrete services provided by individual professionals, board structures and functions will need to be more universal. A challenge may arise as boards consolidated around such health service delivery areas as medical/nursing or oral health care, could intensify the inter-professional conflict often averted when one board is isolated from another. A majority of public membership and equal representation of member professionals could ease potential conflict.

RELATED TOPICS FOR DISCUSSION

- Recruitment and appointment of all board members
- Constituencies represented by board members
- Percentage of public membership
- Reimbursement of board members
- Regional professional boards
- International collaboration

5

INFORMING THE PUBLIC

Providing practitioner information to improve board accountability and to assist the public in making informed decisions about practitioners.

RECOMMENDATION

Boards should educate consumers to assist them in obtaining the information necessary to make decisions about practitioners and to improve the board's public accountability.

Policy options for state consideration:

- Collect information about health professionals and make that information accessible and understandable to the public unless the law forbids disclosure or there is a compelling public policy reason that mandates confidentiality. The burden in disclosure decisions rests with those seeking to restrict access to information. The “compelling” criteria which prevents disclosure should be publicly available and specifically explained when an individual request is denied.
- Develop individual profiles for regulated health care professionals who deal directly with consumers.

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A father recently called the Colorado Board of Medical Examiners to inquire about a physician who would be operating on his daughter the next day. Following Colorado's policy to disclose all information regarding board actions against practitioners, the representative told the father that a letter of admonition had been issued against the physician for an act of substandard care in 1993. The representative could not, however, reveal other information detailing what had triggered the admonition. If the father could have read the file, he would have learned that a malpractice insurer paid a \$1 million settlement on behalf of a child who was left permanently brain damaged after surgery performed by this physician. As is common with many civil malpractice settlements, the terms included complete confidentiality even after the settlement was reported to the board. The moral of this story is that even the most determined health care consumer cannot make truly informed decisions when selecting a physician.

THE ISSUE

Though policies vary by state and by board, health professions boards have traditionally declined to divulge much of the information they collect about practitioners. This restricted information includes disciplinary actions taken, number of complaints filed, malpractice settlements, and adverse actions taken by hospitals and peer review organizations. As a result, the public and the media often perceive health professional regulatory boards as inaccessible and unresponsive to their quest for information about practitioners. The reluctance to disclose disciplinary information fuels the perception that regulators are not working “in the public interest” and see themselves beyond public accountability.

**Policy options for
state consideration:**

(continued from previous page)

These profiles should include legally disclosable information about demographics, education, practice, employment, disciplinary actions, criminal convictions, and malpractice judgments.

In addition to the issues of accountability, current regulatory policies on the disclosure of information impedes the protection of the public. Consumers need and want to make informed choices about their health care practitioners. The trend toward managed care, cost containment, and treatment outcomes research is likely to increase the consumer's need for education and information about providers. For example, a patient should be able to find out if her doctor has lost or settled numerous malpractice cases for precisely the type of procedure she is considering. Limited access to information about health professionals' performance and disciplinary history contributes to information asymmetry in the health care marketplace, inhibiting effective consumer participation.

Regulatory agencies have minimized their roles as educators and information resources to the public regarding consumer protection and quality assurance. The public needs to understand how regulatory bodies and boards function; how regulation affects the cost, quality, and accessibility of care; how they may participate in shaping regulatory standards and processes; and how they, as consumers, can gain access to information about quality, protection, or complaints.

Finally, current information disclosure regulations are inefficient. As with other parts of the regulatory system, they lack uniformity across states and across professions. Consumers must call as many different boards as the number of health professions they have dealt with to obtain the information they seek. For many professions, a state verifying the credentials of a licensing applicant from outside the state must contact all 50 state boards individually. The National Practitioner Data Bank (NPDB), established to alleviate this problem (♦ *See Issue 10 – Understanding the Organizational Context of Health Professions Regulation*), has been beset by problems and limitations; it covers only a few professions and types of information. More importantly, NPDB access is limited to state boards, some potential employers, and individual practitioners as to their own records; it is not available to the public (Furrow et. al., 1995; Wolfe, 1993).

INNOVATIONS AND OTHER APPROACHES

Recent developments in information disclosure may indicate a trend toward responsiveness and accountability. In response to a court decision, the California Medical Board now responds to requests for information regarding any physician or surgeon licensed in California. When available, the information disclosed will include: current licensure; medical school graduation; any public document filed against the physician or surgeon and its nature; reported medical malpractice judgments of \$30,000 or more; reported disciplinary action imposed by another state or federal government; and California felony convictions. There is no restriction on who may request information, although requests may be limited to three physician profiles per call (Bureau of National Affairs, California, 1994).

Massachusetts is also considering expanding its rules regarding information disclosure. In its April 1995 report, *Making Informed Choices about Doctors*, the Advisory Committee on Public Disclosure of Physician Information recommended to the Secretary of Consumer Affairs that physician information currently kept confidential should be made public. The committee was guided by two principles: 1) all reliable information in the board's possession that could be helpful to the public in choosing doctors should be released, unless there is compelling public policy reason to keep it confidential; and 2) judgments and dispositions regarding a physician's competency, which result from adversarial or due process proceedings, provide reasonably reliable information.

Citing the growing need for patients to make informed decisions about the physicians who will treat them, the Massachusetts committee recommended the following types of physician-specific information be released to the public: medical malpractice claims and settlements; hospital and health

care facility disciplinary actions; felony and serious misdemeanor convictions; education and training information; and employment and credentialing history including any restrictions on a physician's license or privileges.

Recent reports and incidents have raised concerns that the regulatory system may not effectively protect the public.

A study of nursing boards found them to be refreshingly open to making information available on request (Citizen Advocacy Center — Nursing, 1993). This information included budgets, census, testing data, licensure activity, disciplinary actions, penalties and corrective actions, and legislative activities. The report found, however, that despite their willingness to provide this information upon request, nursing boards were not proactively making it available to the public.

Finally, Medicare Peer Review Organizations' outreach programs have emphasized strategies that inform the public about their regulatory activities. Outreach includes printed brochures with basic statistical analysis of their actions, targeted presentations, citizen advisory committees, public service announcements, and toll-free information numbers (Citizen Advocacy Center - PROs, 1993). Many of these outreach programs include evaluation mechanisms for judging their effectiveness.

CHALLENGES FOR THE 21ST CENTURY

Recent efforts to increase the disclosure of information about health care practitioners to the public do not go far enough. Thoughtful decisions need to be made about the type of information disclosed as well as the processes and contexts for disclosures. In addition to considering requests to disclose available information, legislators and regulators must serve as educators to help the public use the information effectively.

Boards should collect and disseminate profiles on all the health professionals they regulate, especially those that deal directly with the public. Although the actual composition of the profiles may vary from profession to profession, each board should consider collecting and releasing the following

information: education and training; employment and credentialing history (including board certifications and restrictions on a practitioner's license or privileges), malpractice claims and settlements; hospital and health care facility disciplinary actions; and felony and misdemeanor convictions.

Disclosure helps improve public perception of boards' accountability and empowers consumers with useful information. Regulation should respect consumers' rights to choose health care providers from a range of safe options. Given appropriate information, consumers should be able to choose competent providers for the care that meets their needs, is affordable, and offers the highest quality and best results.

RELATED TOPICS FOR DISCUSSION

- Funding and resources for information collection and disclosure
- Providing contexts for practitioner profiles
- Improving the effectiveness of the National Practitioner Data Bank
- Discipline and malpractice action reporting thresholds
- Malpractice settlement confidentiality

6

COLLECTING DATA ON THE HEALTH PROFESSIONS

Supporting planning for an effective health care workforce.

RECOMMENDATION

Boards should cooperate with other public and private organizations in collecting data on regulated health professions to support effective workforce planning

Policy options for state consideration:

- Use regulatory mechanisms to collect a workforce data set to facilitate timely and informed workforce policy development. Regulatory agencies would not have the responsibility to analyze the data that they collect but, respecting disclosure and confidentiality laws, would share it with other public and private agencies.
- Work collaboratively with other public and private agencies that use such data for health policy planning to identify a standard health personnel data set which is comparable, compatible and accessible.

The synthesis and dissemination of health services research can play an important role in the process of policy formulation and implementation. After all, the process inevitably proceeds on the basis of deeply held perceptions that may have been shaped by personal experience, by anecdotes, or by formally structured information from a variety of sources. Sometimes these perceptions may be an accurate reflection of the facts. At other times, however, they will rest on the most casual of empirical bases and border on folklore. Health services research seeks to bring the perceptions of decision makers as closely as possible to the facts of a situation.

—Shortell and Reinhardt

THE ISSUE

Data collection systems are important tools for improving all aspects of health care, including health care workforce policy. A necessary prerequisite to the development of policy that is meaningful, realistic, and effective is a solid base of accurate data about the numbers, distribution and service capacity of health professionals.

Without information about the professions, policy makers cannot effectively address issues of access, supply, cost and barriers to care. States have failed to take advantage of the opportunities afforded by data collection systems to describe the supply of various health professions in all geographic regions (Intergovernmental Health Policy Project — Health Care Reform, 1994). This dearth of data limits policy makers' abilities to generate hypotheses, study practice patterns, and guide a wide range of public policies. Moreover, data limitations affect a state's ability to designate national shortages and to understand the migration of medical students, residents, and providers across state lines.

State health workforce planning to date has been limited to discrete attempts to ameliorate provider shortages and distribution problems, rather than by standardizing comprehensive data collection, analysis, and action (Intergovernmental Health Policy Project — Health Care Reform, 1994). Health workforce data collection, analysis, and planning responsibilities are typically fragmented among a number of federal and state agencies, all of which are plagued by limited resources (Wing and Salsberg, 1992). Furthermore, comprehensive efforts at data collection and use have been inhibited by a lack of common definitions, high costs, legal and political debates, and patient or provider confidentiality issues (Epstein and Kurtzig, 1994).

Traditionally, state regulatory mechanisms have not served as instruments for data collection.

Although a few professions have made admirable efforts to collect data, non-physician and non-nursing health professionals are not tracked in a systematic manner. Data collection often is done by professional organizations such as the American Medical Association or the American Academy of Physician Assistants, for example. These reports, usually the result of membership surveys, may be incomplete, inaccurate, and unreliable (Kindig, 1994).

Traditionally, state regulatory mechanisms have not served as instruments for data collection. Most regulatory agencies are — or perceive they are — chronically underfunded and understaffed, or don't consider data collection and analysis within their mandate. Though they are in a unique position to collect data on regulated health practitioners, critics justifiably argue that conflicts of interest and anti-trust implications make it inappropriate for regulatory bodies — dominated as they are by the regulated professionals — to analyze data regarding supply and demand of the professions. However, as the official link between the state and the licensee, regulatory bodies are in the best position to collect data effectively and efficiently and share it with policy makers.

INNOVATIONS AND OTHER APPROACHES

More than half the states have, or are establishing, health care data collection systems (Intergovernmental Health Policy Project — Health Care Reform, 1994). The Wisconsin Network for Health Policy Research has discussed how state government could help develop health plan performance measures. The resulting statewide systems would provide public information on the performance of health care plans (Dunham, 1995).

In some of these data collection efforts, states are tying workforce data collection to existing regulatory processes. Colorado, for example, collects data on physician and nursing workforces through anonymous questionnaires distributed with re-licensing information. Unfortunately, lack of resources has precluded analyses of the responses. Virginia has mandated responses to workforce questions as part of re-licensure; South Carolina has been collecting similar data for 20 years; and Georgia, New York, Minnesota, and Vermont have initiated voluntary data reporting systems.

In Maine, only physicians are currently surveyed during re-licensure. However, the Maine Health Care Reform Commission recommends that boards and agencies responsible for licensing facilities collect a health professions data set for planning purposes (Maine Health Care Reform Commission, 1995). The Commission also recommends that these boards and agencies be required to transfer this data in computerized form to the Maine Health Data Organization on a regular basis. Washington state has considered regulations mandating providers to submit data collection forms. Currently, a voluntary system is in place with response rates ranging from 65% to 99%. Meaningful data analysis requires a response rate that consistently approaches 100%.

CHALLENGES FOR THE 21ST CENTURY

Because most health professionals are licensed, certified, or registered by state boards or departments, a fundamental link already exists between the professions and state regulatory agencies. This connection could support accessible, standardized and simple statewide data collection for health workforce analysis and planning. The collection of basic workforce data by regulatory agencies would greatly increase the effectiveness of both the current regulatory system and the larger health care system. For example, with complete information on surfeits and shortages of types of providers, policymakers can devise incentives for improving their distribution.

State boards, working cooperatively with personnel planning and analysis agencies from the public and private sectors, could establish a standard health personnel data set that would be comparable, compatible, and accessible. This data set could include, for example: primary and secondary specialty; board or specialty certification; continuing education completed; hospital admitting privileges; ethnic origin; institutions attended for education and professional training; research and teaching activities; practice location; and licenses/certificates from other states.

State data systems are likely to need substantial financial investment to accomplish these goals. The development, maintenance, and expansion of data collection and analysis systems will succeed only if they are supported with adequate resources (Epstein, 1994). In addition, data must be translated into usable and understandable information for consumers, providers, purchasers, and policy makers. Consequently, it is likely that regulatory board members and staff would need additional support and training in data collection systems.

RELATED TOPICS FOR DISCUSSION

- Funding for data collection
- Confidentiality and privacy issues
- Tracking of unregulated health professions
- Conflicts of interest and anti-trust implications of workforce planning by boards

7

ASSURING PRACTITIONER COMPETENCE

Assessing the continuing competence of health care practitioners.

RECOMMENDATION

States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.

Policy options for state consideration:

- Require the regulated health professionals to periodically demonstrate competence through appropriate testing mechanisms. Competence assessment testing could be:
 - “triggered” by a variety of markers, including for example, the number of disciplinary actions, lack of specialty or private certification, length of time in solo practice, number of procedures performed, or other state-determined indicators; and
 - random or targeted peer reviews for practitioners.
- Cooperate with the relevant private sector organizations and with other states to
(continued on next page)

There is no research available either in Colorado or anywhere in the nation that shows any correlation between linking continuing education with license renewal and the continued competence of any licensed group. The Board believes it must concentrate its emphasis and resources in areas that are demonstrably related to public protection.
— Colorado Board of Nursing deciding to drop its mandatory continuing education requirements for nurses. February 1994.

THE ISSUE

Protection of the public begins when the state grants a professional license based on the individual’s demonstrated command of the profession’s relevant body of knowledge and fulfillment of entry requirements (♦ See Issue 2 – *Standardizing Entry-to-Practice Requirements*). Continuing public protection, however, is not assured solely by the initial licensure. The expanding body of health sciences and practice knowledge, changing health care systems and technologies, and transforming scopes of practice require that practitioners continue to learn and improve their knowledge, skills and clinical judgment throughout their professional careers. The credential earned at the beginning of a career may have little direct relationship to skills used and required later in practice.

Generally, states do not impose specific requirements on licensed professionals to demonstrate their continuing competence to practice. Approximately half of all state medical and nursing boards require licensees to take continuing education courses to maintain their licenses (Citizen Advocacy Center — Continuing Competence, 1995). Continuing education requirements, with few exceptions, ask only that licensees show

**Policy options for
state consideration:**

(continued from previous page)

develop and use standard continuing competency examinations to test minimum competence for continuing practice.

- Support the expanded use of modern technological tools to enhance traditional competencies and their assessment.

they have attended approved continuing education courses. The continuing education courses they select may not necessarily address the areas where the professional needs improvement. The relevance of the chosen courses to the licensees' specific practice, or whether licensees understood the course material, are subject to limited regulatory review.

Most continuing education programs do not consider whether the health professionals enrolled know how to apply their new knowledge in appropriate situations (Shimberg, 1987). One author has asserted that less than ten percent of all inadequate medical practice is due to a lack of practitioner knowledge (Meyer et. al., 1981); another observed that only six percent of hospital-based physician deficiencies resulted from a lack of knowledge (Stein, 1981). Furthermore, some studies have even questioned the correlation of superior knowledge retention to professional performance, suggesting

that an individual's ability to "bring order to the informational chaos that characterizes one's everyday environment" determines whether that professional continues to perform competently (Pottinger, 1977). Recent research also indicates there is little evidence of a demonstrated relationship between participation in continuing education programs and job performance or clinical outcomes (Gross, 1994).

In Ontario, we are saying that competence is knowledge, skills, judgment and the application of knowledge, skills and judgment. It is the application that is really important. It is immaterial if you have all the knowledge and skills and judgment in the world if you are unable to apply it in the actual practice setting (McCrone, 1995).

Acknowledging the failure of continuing education to guarantee continuing competence, boards are dropping continuing education requirements (Colorado Board of Nursing, 1994). Unfortunately, they are not taking the next step: to address the decades-old problem of guaranteeing continued competence. Professionals and regulators tend to agree more on the limitations of mandatory continuing education, rather than on such acceptable alternatives as re-testing or recertification.

Periodic re-testing is uncommon and rarely required for state re-licensure. Professionals view re-testing as a punitive, rather than as a remedial action for guaranteeing continuing competence. Re-testing is perceived to pit the profession's need for beneficial practice improvements against the regulatory mandate to remove incompetent practitioners (Norman et. al., 1993). Writing about the controversy surrounding continuing competence assurance, Salman (1981) declares that,

There is no question that re-certification or re-licensure proposals face both political and psychological barriers. But, if the occupations themselves do not assist in taking the steps necessary to assure the public

that credentialed practitioners maintain or improve their skills after entering practice, the occupations will face pressures from consumers and others for either more restrictive regulations to assure a greater measure of competence or, at the other end of the scale, total de-regulation. Either may be impossible to bear.

INNOVATIONS AND OTHER APPROACHES

Some state agencies have overcome the resistance to re-testing and re-certification for continued professional practice. In California, certified emergency medical technicians (EMT-1) are required to demonstrate their continuing competence every four years by passing a competence-based written and skills demonstration exam (California Code of Regulations, Title 22). Additionally, all EMT-1s must complete required continuing education courses every two years. They take either an approved 24-hour refresher course addressing essential knowledge and skills, new technologies, and recent developments in basic life support, or a combination of approved continuing education courses focused on pre-hospital emergency care.

Re-testing such as this is also applied to more sophisticated professions. At the federal level, the Federal Aviation Administration requires professional pilots be re-tested regularly to demonstrate their flight skills (Federal Aviation Administration, 1995). Pilots who log more than 400 hours of flight time in a year are re-tested every two years. Pilots who log fewer than 400 hours of flight time annually are re-tested every year. Moreover, pilots who have not performed certain maneuvers regularly may not be put in charge of commercial aircraft. To command a commercial aircraft, a pilot must have completed three night takeoffs and landings in the preceding 90 days.

The College of Physicians and Surgeons of Ontario, Canada employs a peer assessment of physicians' office practices, based primarily on record review, to identify physicians who may need remedial training to correct practice deficiencies. Peer assessment is conducted by specially trained practicing physicians who review a random sample of patient charts in the targeted physician's office. When problem areas are identified, the physician has six months to improve. This targeted retraining program employs various materials and approaches — oral and clinical examinations, chart-stimulated recall, and trained standardized patients — and claims a high success rate in identifying and improving areas of deficient practice (Norman et. al. , 1993).

In the private voluntary sector, some medical specialty boards require rigorous demonstrations of competence for both initial and continued specialty certification. The American Board of Family Practice, for example, requires that board certified family physicians demonstrate competence every seventh year through cognitive testing and office records reviews (American Board of Family Practice, 1995). Other medical specialty boards issue time-limited certifications, usually lasting from seven to ten years.

A number of professional boards employ mandatory remedial education to address identified deficiencies of practitioners who have come before the boards in disciplinary proceedings. This process is criticized as inadequate because it identifies poor performance after the damage has been done (Massaro and O'Brien, 1983). Public protection and practice performance would be improved

if states pro-actively identified practitioners at high risk for poor performance, for example, those without a specialty or private certification or those in solo practice. Even more proactive would be state-required random or targeted peer reviews.

CHALLENGES FOR THE 21ST CENTURY

The evidence that continuing education cannot guarantee continuing competence is sobering. State legislatures will be challenged, therefore, to require each professional board to develop continuing competence requirements that do not rely on continuing education. State regulation of health care practitioners will be more effective and efficient in protecting the public when practitioners can demonstrate competence throughout their careers. Emerging information technologies and the information super-highway offer states unprecedented opportunities to create innovative means of assessing both initial and continuing competence.

State boards will face the challenge of defining and developing continuing competence methods that are standardized, effective, and feasible. Re-testing programs, for example, should assess the competence of practitioners according to articulated practice guidelines, provide specific and detailed feedback to practitioners, offer targeted retraining for deficiencies, reassess the practitioner's skills after retraining, and remove those practitioners whose performance, after retraining, does not meet identified standards. State boards may not have to require re-testing for all practitioners. Private board certification and re-certification or institutional competence assessments may serve as appropriate proxies if states determine they guarantee continuing competence.

RELATED TOPICS FOR DISCUSSION

- Practitioner retraining
- Defining “competence”
- Information management competence
- The role of clinical practice guidelines in continuing competence
- Facility accreditation continuing competence requirements

8

REFORMING THE PROFESSIONAL DISCIPLINARY PROCESS

Protecting and promoting the public's health in an accountable, timely and fair manner.

RECOMMENDATION

States should maintain a fair, cost-effective and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health.

Policy options for state consideration:

Detection

- Establish an authoritative body, or assign such responsibility to an existing body, which would oversee the complaints, resolution and discipline processes for all professions to ensure that boards are acting uniformly, equitably and in the interest of public protection.
- Establish uniform complaints and discipline processes for all regulated health professions to ensure that all investigations of complaints are handled in an objective, prioritized, and timely manner. The concerned parties should be informed of the progress of the complaint and investigation on a regular basis.

(continued on next page)

In West Virginia, a physician pleaded guilty to repeatedly telling teenage girls on whom he performed pelvic examinations that they were pregnant when he knew this information to be false. The physician stated that he used this "play" in his treatment so that his patients could get a glimpse of how they would feel if they were to find out they actually were pregnant. The complaint originated from the parents of a 14-year-old girl who had been given a pillow case to cover herself while the physician watched her undress. The investigation also revealed that the physician had been illegally prescribing controlled substances.

A consent order stipulated that the physician's license would be suspended until he paid a \$2,000 fine, successfully completed a Board-approved course in rational drug therapy, and undertook a course of study with a Board-approved gynecologist regarding the appropriate manner in which to conduct gynecological examinations. Most likely, he will be back in practice within a few short months.

—Swankin and Willette, 1993

THE ISSUE

State professional licensing boards are charged with the responsibility of investigating complaints and disciplining health professionals whom they find to have violated statutes, rules or regulations governing a particular profession. In carrying out their responsibilities, many health professional licensing boards find themselves facing decreasing budgets and increasing public criticism on how they perform the disciplinary function.

The problems and criticisms fall into four general areas. First, information about the complaint process and disciplined health

**Policy options for
state consideration:**

(continued from previous page)

- Make public access to the complaints and discipline process simple and clear. Information about filing a complaint, the standards by which complaints are judged, investigation procedures, discipline, and appeals should be explained in a manner that is simple and clear.

Resolution

- Employ resolution processes that are best suited to the parties and dispute, including alternative dispute resolution methods.
- Discipline practitioners using the best available tools including rehabilitation, targeted education, settlement, and punitive actions.

(continued on next page)

professionals is not made generally available to the public, making it difficult for aggrieved consumers to determine who can help them resolve their problems with licensed health professionals or make informed choices about who should provide their health care. Second, members of the public who complain to boards are frequently not informed about the progress of their complaints or allowed to participate in the proceedings. Third, boards are not seen as vigorously pursuing allegations of health professionals' misconduct or incompetence. Finally, when boards do act, they are frequently criticized for taking far too long to resolve a complaint, and for imposing inappropriate or ineffective sanctions.

Consumers often do not know where to turn when they have problems with a licensed health professional. Confusion is so widespread that even advice columnists, such as Ann Landers and Dear Abby, who receive numerous letters on the topic, have told their audiences to write to local medical associations, rather than licensing boards, when they have received substandard care from a medical professional. The problem is exacerbated by the differences between states and between professional boards within a state on complaint policies and procedures. Consumers rarely understand that two health professionals who provided them with care at the same site must be reported separately to their respective boards, using different forms and following different protocols. Licensing boards also fail to provide information about disciplinary actions they have taken. In a time when consumers are expected to make informed choices about their health care practitioners, they

need reliable information (♦ See Issue 5 – *Informing the Public*).

Should a consumer successfully file a complaint with the correct agency or board, he or she is often left in the dark about the progress of the complaint. Although many boards make efforts to inform the public about how their complaint is progressing, not all boards are so conscientious. For example, a study in one state revealed that the medical board acknowledged in writing only one out of thirty complaints received, and failed to contact the complainant entirely in one out of every four of its cases (Jost, et.al., 1993). This study concluded that even if the complaint did not lead to the instigation of disciplinary action, the complainant deserved a response to their complaint. Furthermore, boards were found to have potentially aggravated the grievance of the complainant by failing to demonstrate that the complaint was being taken seriously.

**Policy options for
state consideration:**

(continued from previous page)

Disclosure

- Ensure that the outcomes of complaints and resolution of investigations are available and understandable to the parties involved, and to the public where appropriate, unless the law forbids disclosure or there is a compelling public policy reason that mandates confidentiality. The burden in disclosure decisions rests with those seeking to restrict access to information. The “compelling” criteria which prevents disclosure should be publicly available and specifically explained when an individual request is denied.

Another criticism is that boards do not pursue incompetent health professionals vigorously. Despite estimates that place the number of substandard physicians at one to two percent of those currently in practice, only a small percentage of physicians, about half of one percent, are disciplined for any reason whatsoever (Gray, 1992; San Francisco Chronicle, 1995). Moreover, although the number of board-issued sanctions have increased in recent years, negligence- or incompetence-based actions still account for a small portion of the total disciplinary actions. In fact, the most frequently imposed form of discipline was a “letter of concern” (Gray, 1992).

A 1994 report of the Arizona Auditor General concerning the Board of Medical Examiners underscores these concerns (Arizona Auditor General, 1994). This report found that physicians often received only a letter of warning when more serious disciplinary action was warranted given the statutory violations and serious nature of the unprofessional conduct. This report also found that the medical board did not act promptly to remove those physicians who were repeat offenders and whose past conduct had resulted in patient harm.

All of this is particularly troublesome for health care consumers, and is amplified by recent headline reports of serious medical mistakes at hospitals in Boston and Tampa

which cost patients their lives and limbs. Furthermore, the Public Citizen’s Health Research Group has estimated at least 80,000 patients are killed in hospitals each year due to negligent practice (San Francisco Chronicle, 1995; VanTuinen and Wolfe, 1991). This estimate is based in part on a Harvard study which found that one percent of a representative sample of patients treated in New York State hospitals in 1984 were injured, and one in four of those died from medical negligence (Harvard, 1990).

Additionally, recent research shows that reporting by hospitals to boards about adverse actions, a significant source of data on incompetent practitioners, is far from optimal and that boards are not aggressive in collecting disciplinary information (Office of the Inspector General, 1995). Moreover, legal actions or malpractice settlements that are imposed are often not passed on to the appropriate professional licensing board (Office of the Inspector General, 1993; The Advisory Committee on Public Disclosure of Physician Information, 1995). These studies indicate the scope and severity of consequences which result from failure to effectively identify and discipline substandard practitioners.

A study of disciplinary actions in Washington state sheds light on how professionally-dominated boards discipline their fellow professions (Ehri, 1995). This study indicated there were significant differences between the frequency of serious disciplinary actions imposed by professionally-run

boards and those boards overseen by a state administrative agency. This report noted that state administrative agencies removed practitioners from practice far more often than professionally-run boards. Removal from practice constituted one out of two of the total number of actions taken by administratively-run agencies, while professionally-run boards only removed licenses in one out of seven of their actions. More significantly, the rate of “symbolic” sanctions was considerably less (one out of thirty) for the secretary-supervised boards than the rate (one out of five) in the professionally-supervised boards.

This chronic under-reporting of discipline against health care professionals is underscored by the problems encountered by the National Practitioner Data Bank (NPDB). The NPDB was created as a central clearinghouse for disciplinary actions taken by various state and federal agencies, such as the Drug Enforcement Administration and the Health Care Financing Administration’s Medicare and Medicaid programs, as well as revocation or limitation of staff privileges taken by hospital and health care networks. Despite the broad reporting mandates of the NPDB, little information has actually made its way into the system. A 1995 report from the Department of Health and Human Services, Office of the Inspector General indicated that only 25% of all hospitals in the U.S. reported any incident to the NPDB during a three year period (Office of the Inspector General, 1995). This has resulted in the widespread perception that these institutions either do not capture or seriously understate the significance of actions warranting discipline (♦ See Issue 5 – *Informing the Public*).

The complaint process is difficult to initiate for the consumer, and many complaints go without investigation.

A fourth criticism is that when boards do act, they take too long. The failure of licensing boards to resolve complaints in a timely manner permits health professionals with problems to continue to practice. One prime reason for the delays may be the volume of complaints about licensed health professionals which has grown steadily in recent years. In some instances, these increases have been dramatic: Washington’s medical disciplinary board handles nearly twice as many physician complaints as it did in 1989, and New York complaints have risen over 300% from 1989 to 1993 (Cohen and Raines, 1994). In 1993, it was estimated that California received over 8,000 complaints about physicians alone (Schubert Associates, 1994).

This increased volume has taxed the resources of most boards and resulted in less than timely resolutions of many complaints. One report noted that heavier caseloads and limited staff continue to translate into a backlog of unresolved complaints and a slower complaint resolution process; in some states the average period for complaint resolution stretches to two years (Cohen and Raines, 1994). The Arizona Auditor General found that even less serious cases, those not involving malpractice or patient safety, took an average of 335 days to resolve (Arizona Auditor General, 1994). Despite innovations to expedite the resolution of cases, many agencies continue to show

large backlogs and slow processes. Frequently, the complainant is excluded from resolution processes and in some instances, cannot even find out how the matter was settled.

INNOVATIONS AND OTHER APPROACHES

Medical boards in the Canadian provinces of Ontario and Alberta, concerned about the limitations of an entirely reactive disciplinary program, have begun to develop proactive programs where targeted office visits are scheduled to ferret out substandard practitioners (♦ See *Issue 7 – Assuring Practitioner Competence*). This is not an entirely new idea. In a number of states, boards of pharmacy have developed proactive programs, surveying pharmacists and inspecting records to uncover any irregularities in prescribing patterns that warrant closer examination.

Still another innovation involves the development of alternative dispute resolution programs to handle those cases that do not raise serious issues of public protection, but nevertheless need to be addressed if the public is to have confidence in, and respect for, their licensing boards. The Massachusetts Board of Registration in Medicine, as one example, recently established a voluntary mediation program to provide a forum for the resolution of some disputes between physicians and patients. To determine whether an offer of automatic confidentiality to licensees is a factor in their willingness to participate in mediation, the board will offer participatory confidentiality to half of the physicians contacted, and inform the other half that successfully mediated cases will be noted on the public record as “successfully mediated” (Cohen & Raines, 1994). The same researchers found that Minnesota’s TRIAGE Agenda expedites cases by identifying less serious complaints and resolving them through an informal meeting between the respondent-physician and a Medical Coordinator. This program has been credited with reducing the case backlog by approximately one-half.

Some states, such as Wisconsin have developed elaborate criteria for categorizing complaints, to assure that the “worst” cases receive the highest priorities. All states with significant numbers of complaints need to develop such policies. A 1993 Citizen Advocacy Center study found that the great majority of boards of nursing and boards of medicine do not have a prioritization system in place (Swankin and Rose, 1993).

Another use for categorization of complaints would be the development of standards to help equate disciplinary actions to the severity of the complaint or violation. In 1993, the California Medical Board recommended the development of a system for prioritizing complaints that require immediate action and further, to link disciplinary outcomes to the severity of the complaint (Medical Board of California, 1993). This standardization would help to ensure fairness and uniformity in all disciplinary proceedings. Other states, including Michigan, Minnesota and Massachusetts, have begun to institute such policies (Cohen and Raines, 1994).

CHALLENGE FOR THE 21ST CENTURY

Boards should consider implementing processes such as complaint prioritization using established criteria and alternative dispute resolution techniques to more efficiently and effectively resolve complaints. By effectively prioritizing complaints, boards would be able to identify those cases

which warrant immediate attention thereby protecting the public from harm by a substandard practitioner. This would also allow for identification of those cases which are best suited for more informal resolution processes and improve the boards' ability to handle the increasing volume of complaints they receive. In addition, uniform disciplinary processes should appropriately link disciplinary action to the severity of the complaint.

Remembering that the boards' primary duty is to protect the public, boards should acknowledge and respond to every complainant in writing. Furthermore, boards should communicate regularly with the complainant about the status of his or her case. Such communication would alleviate increasing criticisms and public perceptions of the boards as ineffectual. Finally, boards should notify the complainant of the outcome or resolution of the case and make all publicly disclosable disciplinary actions available to the public. By providing the public with information about its complaints and disciplinary processes and outcomes, public accountability is greatly improved.

RELATED TOPICS FOR DISCUSSION

- Alternative Dispute Resolution imperfections (confidentiality issues, absence of board presence)
- Board members' roles in disciplinary actions
- Appropriateness of sanction compared to severity of problem

9

EVALUATING REGULATORY EFFECTIVENESS

Ensuring that health professions regulation protects and promotes the public's health.

RECOMMENDATION

States should develop evaluation tools that assess the objectives, successes and shortcomings of their regulatory systems and bodies to best protect and promote the public's health.

Policy options for state consideration:

- Regulatory bodies and processes should be subject to periodic external (e.g., sunset type according to agreed upon objective standards) and internal (e.g., self-evaluation assessment based on set criteria) evaluation. Criteria for evaluation might include:
 - timeliness of adjudication process;
 - public perception of and satisfaction with regulatory processes and accountability; and
 - effectiveness of boards at meeting their mission and objectives.

Performance accountability can speed the rate at which innovations spread throughout a human service system, because successful practices will show up in reports to political leaders... Performance accountability gives political leaders more information with which to make crucial resource allocation decisions... Finally, allocating resources based on performance can free both policymakers and service providers from the necessity of specifying through rules and regulations exactly what providers do. In this sense, accountability systems can provide the basis for a new way of governing — through the measurement of performance rather than through the bureaucratic process.

—Brizius and Campbell, 1991

THE ISSUE

Currently, there is little standardized or systematic evaluation of the health professions regulatory system — its structures, policies and processes — to assess objectively whether it protects and promotes the public's health. Critics point out that the evaluation and research of health professions regulation tend to reflect professional rather than public interests, and information collected reflects the values and viewpoints of the professions and institutions, and not necessarily the effectiveness and efficiency of the system in meeting its public mandate (Smith, 1994).

A 1995 report to the Massachusetts Secretary of Consumer Affairs and Business Regulation found that there were no systematic tools by which to measure the performance of medical boards and that this inability resulted in negative public perceptions of medical boards (Advisory Committee on Public Disclosures of Physician Information, 1995). The evaluations that do exist indicate that public expectations for

professional regulation serving the interests of consumers have not been met (Arizona Auditor General, 1994). Although information useful for evaluating regulation is collected by different sources, it is fragmented and focused on specific areas of professional practice (Wing and Salzberg, 1992). These sources include state professional boards, peer review organizations, institutional accreditation bodies, and private malpractice insurers. Each body employs different measurement tools and emphasizes different aspects of performance, such as number and nature of disciplinary actions, speed of adjudication or malpractice settlements — with little attempt to collect an entire data set on a standardized or coordinated basis. This lack of a coordinated approach to practitioner and regulatory performance review inhibits a comprehensive evaluation of health care workforce regulation.

Regulatory systems have largely failed to implement mechanisms to evaluate their effectiveness and correct shortcomings.

Successful board and regulatory evaluation requires both internal and external assessments. Internal self-assessments allow boards to regularly examine operations and make improvements. External assessments provide more objective viewpoints; some of the most constructive criticisms of boards have come from Auditor General reports, appointed Blue Ribbon committees, sunset reviews, and even in-depth investigative reports by the media.

INNOVATIONS AND OTHER APPROACHES

Many states require or encourage professional boards to conduct self-assessments. In the state of Washington, for example, most boards undertake self-assessments to evaluate processes and workload, recognize success, identify areas for improvement, and establish biennial goals and objectives. The assessments examine laws, rules and policies, testing, disciplinary processes, education and outside relationships.

In 1992, the Federation of State Medical Boards developed a comprehensive self-assessment tool (Federation of State Medical Boards, 1992). Developed under a federal contract, the “self-assessment instrument” employs over 300 questions to review all areas of board responsibility. The questions are arranged according to seven board activity areas: organization and administrative affairs; physician licensing; discipline; education/communication/information; legislative and policy activities; impaired licensees; and allied health professions. Each activity area is further broken down. The discipline section, for example, examines power and duties, sources and management of complaints, discipline activity/process, action time frame, monitoring, and counsel/expert witness.

Legislative sunset audits and reviews, another form of evaluation, are generally more comprehensive than self-assessments. They usually examine internal efficiency and the external impact of regulation on meeting its principal purpose: to protect the public’s health, safety and welfare. Although concerns remain and some states have discontinued their use, sunset reviews conducted properly have increased the accountability and effectiveness of state agencies (Kearney, 1990).

One such sunset review, recently conducted by the Arizona Auditor General (1994) of the state medical board, may provide guidance in developing sunset standards for all professional boards in the effective evaluation of regulatory performance. The criteria employed in this performance report were:

- Objective and purpose in establishing the board.
- The effectiveness with which the board has met its objectives and purpose and the efficiency with which the board has operated.
- The extent to which the board has operated within the public interest.
- The extent to which rules adopted by the board are consistent with the legislative mandate.
- The extent to which the board has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public.
- The extent to which the board has been able to investigate and resolve complaints that are within its jurisdiction.
- The extent to which the attorney general or any other applicable agency of state government has the authority to prosecute actions under the enabling legislation.
- The extent to which the board has addressed deficiencies in its enabling statutes which prevent it from fulfilling its statutory mandate.
- The extent to which changes are necessary in the laws of the board to adequately comply with the factors listed in the sunset laws.
- The extent to which the termination of the board would significantly harm the public health, safety, or welfare.
- The extent to which the level of regulation exercised by the board is appropriate and whether less or more stringent levels of regulation would be appropriate.
- The extent to which the board has used private contractors in the performance of its duties and how effective use of contractors could be accomplished.

In Colorado, sunset evaluation criteria question the necessity of regulation given current conditions and whether the board's composition and operations effectively and efficiently serve the public interest (Colorado Department of Regulatory Agencies, 1994). The professional disciplinary mechanism also is reviewed for its effectiveness in protecting the public. Finally, regulation, and in particular scopes of practice and entry requirements, are reviewed for their overall economic, competitive and workforce utilization impact.

CHALLENGES FOR THE 21ST CENTURY

Both sunset and self assessment approaches hold promise for the improved evaluation of regulation's effectiveness and efficiency. Before these can be evaluated, concrete objectives for the regulatory system and standards by which to measure its performance must be articulated clearly. Current sunset and self-assessment measures, such as number of complaints processed, timeliness of the adjudication process, and disciplinary actions taken, address the efficiency of internal board operations but say little about regulation's overall effectiveness in protecting the public's health.

To address larger effectiveness issues, all states should consider adopting sunrise and sunset laws that require legislators to review critically any requests for regulating new professions, and perhaps more important to review the benefits of continuing to regulate all existing professions. Such evaluation should measure operational efficiency, the effectiveness of boards at meeting their missions and objectives, and public perception of, and satisfaction with, regulatory processes and accountability. Moreover, sunset and other evaluation criteria will need to be standardized across the professions and states for ease of comparison.

Lastly, the challenge remains to ascertain whether these largely internal assessments will be done objectively and result in actual change in regulatory structure, policy, and process. Professional boards will be challenged to identify all of their internal and external constituents — professionals, health care delivery providers, and the public — and incorporate them into the development, analysis, and modification of regulatory evaluation criteria and standards.

RELATED TOPICS FOR DISCUSSION:

- Political issues of sunset reviews
- Data collection for regulatory evaluation
- Stakeholder involvement in evaluation

O

UNDERSTANDING THE ORGANIZATIONAL CONTEXT OF HEALTH PROFESSIONS REGULATION

Developing effective partnerships among state, federal and private regulatory systems to streamline health professions regulation.

RECOMMENDATION

States should understand the links, overlaps and conflicts among their health care workforce regulatory systems and other systems which affect the education, regulation and practice of health care practitioners and work to develop partnerships to streamline regulatory structures and processes.

Policy options for state consideration:

- Study the interplay between state health professions regulatory systems and the systems listed below to evaluate where links should be forged or broken, where redundancies could be streamlined or removed, where conflicts exist and can be resolved and where gaps demand attention:
 - reimbursement
 - accreditation
 - professional associations
 - legal system (civil & criminal)
 - testing
 - facility regulation
 - federal government

It is likely that no deep understanding of the role of professional groups in society — including their degree of autonomy in individual workplaces — is possible without understanding the role of states and markets in 1) the education of professional groups or cadres; 2) the nature and conditions of their employment in “free professional” (petit bourgeois or self-employed) status or state locations; and 3) the overall evolution of the relationship between two organizing forces — state and market — with respect to goods and services.

— Elliot A. Krause.

Professions and the State, 1991

THE ISSUE

The regulation of more than 100 health occupations or professions in one or more of the 50 states is a study in organizational inconsistency and complexity. Health care quality assurance and consumer protection have traditionally resulted from the interplay of several separate, poorly coordinated systems: state and federal regulation of professions and facilities; voluntary private certification; educational and facility accreditation; standards for competence measurement by examination; tort law; and reimbursement for services. Moreover, the agendas and actions of professional associations and private associations of government regulatory boards influence each of these systems, processes and the interplay between them. In some cases, these linkages are so strong that reform of one element must be complemented by reform in another to be effective.

Decisions related to health professional regulation, both public and private, affect the division of labor and the allocation of practice rights, and therefore, the cost, quality and accessibility

of health care services. Few partnerships exist among the current plethora of disparate regulatory systems. The need for a comprehensive and rational health care workforce policy, including regulatory policy, transcends issues related to the regulation of specific health occupations and professions.

A comprehensive depiction of the webs of affiliation among state regulatory bodies and other public and private organizations is beyond the scope of this report. Instead, the following organizational contexts are discussed briefly to 1) illuminate their connections with professional regulation, and 2) illustrate the roles they could play in developing a state health professional regulatory system that is standardized, accountable, flexible, effective, and efficient in protecting and promoting the public's health, safety and welfare.

Reimbursement

H *Health care quality
assurance and consumer
protection have traditionally
resulted from the interplay
of several separate, poorly
coordinated systems.*

The link between state licensure and third-party reimbursement is often direct. To be reimbursed for services, practitioners usually must be licensed and the services they provide must be included in a regulated scope of practice. Tying third-party reimbursement to regulated professionals has had provocative effects. For example, the National Clearinghouse on Licensure, Enforcement and Regulation (1986) views this linkage as placing a heavy burden on state legislators to enact new licensing statutes for many unlicensed mental health and allied health professions. Licensure and scope of practice tied to reimbursement are generally the result of professional initiatives targeted at securing health care payments.

Professional practices may be as limited by reimbursement policies as by state laws and regulations governing authority or competence. Medicare, Medicaid, and most private health insurance companies need only limit payment to chosen professions. These payment actions, in turn, become the mechanisms for assessing quality and competence of professionals to provide medically necessary services (Burde, 1994). As a result, services are not reimbursed in a standardized manner. For the same services, some professionals are reimbursed while others are not; those who are may be reimbursed at different levels (Safriet, 1994). Alternatively, by expanding reimbursement coverage for services to "any profession" that operates within state law, the market pushes professionals to fight the scope of practice battles in state legislatures.

CHALLENGES FOR THE 21ST CENTURY

Capitated payments will fundamentally alter how services are reimbursed and consequently, who provides those services. The cost-saving imperatives explicit in capitation will move service delivery to the least costly practitioners. Moreover, third party payers likely will focus more on services than on providers when determining reimbursement. Ultimately, reimbursement for services should be

standardized. State regulatory bodies and third-party payers will face the challenge of collaborating to ensure that economic incentives do not undermine the quality of care. The “least costly provider” should demonstrate initial and continuing competence to provide services.

Accreditation

The most common requirement for entry into regulated health professional practice in any state is graduation from an educational program approved by the state licensing board (♦ *See Issue 2 – Standardizing Entry-to-Practice Requirements*). In virtually every state and for every profession, approval means that boards defer to private, voluntary organizations that accredit educational institutions or programs. Some accrediting programs remain integral parts of national professional associations; others have spun off, but the majority continue to be controlled by professional interests.

Boards of nursing, for example, grapple with a potential conflict-of-interest by accrediting educational programs (usually a voluntary private agency function in other professions) and licensing the graduates of these programs at the same time. Because accreditation means survival for education institutions, and is required for licensure eligibility, it is a powerful force in shaping educational policies, licensure requirements, and the types of graduates entering the workforce. Accreditation standards and processes also have been criticized for not keeping up with advances in professional knowledge and health care technology — thereby limiting innovation and perpetuating stagnant curricula (Gelmon, 1995). Others note that neither health care employers, payers, nor the public are involved effectively in discussions of these standards (Begun and Lippincott, 1993). Consequently, public trust in accreditation has eroded because of the perception that self-regulation mechanisms are invisible or seem unresponsive to the public (Western Association of Schools and Colleges, 1993).

These criticisms are not limited to health professions. They apply to all professions where educational accreditation and professional licensing are linked informally and state authority is perceived as ceded to private professional interests. This automatic deference to professionally controlled accreditation processes has come under increased scrutiny. In a well-publicized case, the Massachusetts School of Law at Andover alleged that the American Bar Association had engaged for decades in an unlawful conspiracy and in concerted action to restrain and monopolize trade through the imposition of unreasonably restrictive and anti-competitive standards for law school accreditation in violation of the Sherman Act (Boot, 1995). Havighurst (1994), an expert in antitrust law and health policy, writes that:

Under the lens of the Sherman Act, many well-entrenched joint ventures in accrediting on which the public is almost exclusively dependent for authoritative information on a wide variety of important

Accreditation standards and processes also have been criticized for not keeping up with advances in professional knowledge and health care technology — thereby limiting innovation and perpetuating stagnant curricula.

commercial and public policy issues begin to look like what they are — conspiracies to ensure that the public hears only the collective opinion of certain industry insiders and is deprived of the benefits of competition in what is essentially a marketplace of ideas. . . . In the field of educational accrediting, anti-trust law could force a restructuring of many powerful joint ventures of which Congress and the Department of Education have been altogether too tolerant.

CHALLENGES FOR THE 21ST CENTURY

As private accreditation bodies mirror the function of state agencies to regulate the workforce, accreditation processes and standards have to be accountable and respond to the needs of the health care system and the public. States may consider alternative accreditation standards and structures to complement or supplant those of professional accrediting bodies. Educational accreditation principles will be expected to evolve with public needs, stimulate education programs to improve continuously, and focus on the graduates' demonstrated competence to perform services appropriate for their level of training. Finally, international trade agreements such as the North American Free Trade Agreement and the General Agreement on Trade and Tariffs will require that states examine similarities and differences in the education, accreditation, regulation and utilization of the health care workforce internationally. This will serve to identify and remove barriers to the international mobility of competent health care practitioners.

Professional Associations

Critics of state licensure have focused on the close ties between professional associations and state regulation, and on the fact that members of the regulated professions dominate the membership of state licensing boards (Gross, 1984). They assert that, historically, professional regulation has resulted from lobbying by professional associations for self-regulation, scopes of practice, and maximal reimbursement — not from public appeals for greater protection (Shimberg, 1984, 1991). To some degree, this “fox guarding the hen house” problem has been lessened by adding public members to licensing boards.

Historically, professional regulation has resulted from lobbying by professional associations for self-regulation, scopes of practice, and maximal reimbursement — not from public appeals for greater protection.

Although state legislators are responsible for determining scopes of practice, the perception that professional associations play a dominant role in this determination is not limited to critics. For example, the Emergency Nurses Association wrote in 1989,

The Emergency Nurses Association (ENA), as the professional organization for the specialty of emergency nursing, is responsible for defining and establishing the scope of emergency nursing practice. In doing so, ENA recognizes the role of the American Nurses Association (ANA) in defining the scope of practice for the nursing profession as a whole.

The same forces that led professional associations to seek licensure in every state also fostered the development of national councils or associations of state professional boards. The activities of these national associations include conducting task analyses and policy studies for the profession, contracting with examination vendors to develop national entry-to-practice examinations, operating clearinghouses of educational materials and disciplinary actions taken by state boards, and conducting annual meetings. As with trade associations, these national organizations focus on the most salient needs of constituent members. Because the national organizations are private associations of state governmental agencies, they may often speak to issues and offer opinions that individual boards as instruments of government cannot.

The link between national professional associations and state professional boards has both positive and negative aspects. On the plus side is the ability of national organizations to standardize testing requirements across the nation. On the negative side, standardization can favor the interests of the professional group involved, rather than the broader needs of society. This is neither strange nor unusual; it is the mandate of a national trade or professional group to protect and promote the interests of its members. Because state regulatory boards are often dominated by professionals, the voices of organized professions are heard more clearly than those of consumers, other health professions, and other interested parties.

CHALLENGES FOR THE 21ST CENTURY

Professional associations that represent health professionals and regulatory boards will face increasing pressure to put public protection and service above institutional and constituent advancement. State professional boards will also be forced to carefully weigh the importance of input from all interested parties into decision and policy-making. As they do so, states may look to professional associations to collaborate on competence assessment for new or multi-skilled practitioners, or other interdisciplinary regulatory endeavors.

Legal System (Civil and Criminal)

The civil legal system is not associated directly with the health professions regulatory system as different standards prevail and different consequences result when standards are violated. A violation of a regulatory standard by a health practitioner can lead to the loss of his or her license, or can require the practitioner to remedy the practice flaw or knowledge gap that led to a sanction. In contrast, malpractice awards occurring in the civil system do not necessarily lead to a change in provider behavior or practice (Smith, 1994).

The indirect relationships between the legal and regulatory systems are important. Many states require that malpractice awards and settlements be reported to licensing boards. This requirement serves to identify substandard practitioners and allows boards to intervene proactively. There is, however, mixed evidence regarding the timeliness, completeness and usefulness of the information provided about malpractice settlements and awards to boards.

Communication between licensing boards and the legal system were infrequent before federal mandates were enacted that require malpractice judgments or settlements, and disciplinary actions taken by state licensing boards, to be reported to the National Practitioner Data Bank (NPDB) (Furrow et. al., 1995). However, only state licensure boards, provider institutions, individual practitioners, and some researchers are allowed to access the NPDB. There is no public access to the information. Provider institutions are required to query the NPDB every two years as a condition of granting privileges. States boards are not required to query it before allowing a practitioner to practice in its state. In addition, much of the information that should be in the NPDB is not being submitted. Finally, the question remains whether reporting thresholds keep settlements and disciplinary actions artificially low to keep practitioners out of the NPDB.

CHALLENGES FOR THE 21ST CENTURY

The broader development and use of clinical practice guidelines may have a widespread impact on malpractice lawsuits, their outcomes and, ultimately, malpractice insurance premiums. Standardized practice guidelines also may be developed for practitioners other than physicians, particularly those who work independently — advanced practice nurses, for example. Those practitioners who work independently — i.e., who have direct access to patients; do not perform their services under supervision, sponsorship or affiliation of another practitioner; and are not rendering services on orders from another health care practitioner — will be expected to carry adequate malpractice insurance (Washington State Department of Health, 1995).

Testing

An almost universal requirement for entry into regulated practice is the successful completion of an examination approved or accepted by the state regulatory board. (♦ See *Issue 2 – Standardizing Entry to Practice Regulations*) In the majority of instances, these examinations are developed by private sector vendors for national use. Use of additional regional or state examinations appears to be declining.

When studies of licensure proliferated in the 1960s and 1970s, federal and other reviews recommended that states conform examination practices to testing industry standards (Shimberg, 1980). A substantial private examination industry has emerged to provide state boards with “psychometrically sound, legally-defensible” examinations. Although examinations required for entry-to-practice meet these standards, there are questions about “credential creep.” This refers to the relationship between knowledge and competence, the relevance of exams to public protection, and some anti-competitive implications of exams (Nelson, 1994).

To address the anti-competitive potential of examinations, Shimberg (1990) proposed a non-governmental agency to monitor and establish standards for the testing industry which controls “high stakes” examinations — those that determine who can teach, who gets admitted to college or graduate school, which applicants get hired for jobs in industry and which people get licensed to enter a profession. Nelson (1994) argues that examinations for licensure in the interest of public protection should test for competency only in those areas of practice that are potentially harmful to the public.

CHALLENGES FOR THE 21ST CENTURY

State boards and national credentialing organizations will be required to ensure that exams are not only psychometrically sound, but measure competency in those areas that put the public at risk. These organizations also will be challenged to justify why they should determine a candidate's competence beyond the components of practice that place the public at risk. Moreover, states should review the accountability of examination development and ask who should determine the knowledge, skills and abilities required for competent practice in the workplace.

Tests should allow individuals from a variety of professions to be tested in a standardized manner for the same sets of competencies. This will include developing examinations that assess multiple competencies, interdisciplinary practice skills, and such new expectations as computer competence. Testing for the future will be challenged to examine whether professionals are competent in the practical application of their knowledge and skills. Finally, test writers should engage non-regulated professionals to develop questions that more directly address the needs of the public.

Facility Regulation

State and federal governments often regulate health care facilities to help them qualify for reimbursements. In addition, a growing number of national organizations attempt to assure health care quality by operating voluntary programs for the accreditation of health care organizations, facilities, and programs. In some cases, states and the federal government will deem private accreditation an appropriate substitute for their licensure processes. The largest of these private organizations is the Joint Commission on the Accreditation of Health Care Organizations (JCAHO). Other organizations include the Commission on Accreditation of Rehabilitation Organizations, and the relatively new National Committee for Quality Assurance that accredits health plans and produces standardized report cards on the performance of managed care plans.

In addition to other factors examined for accreditation or performance reports, health plans must demonstrate that they maintain a qualified and competent staff. For example, the JCAHO requires current licensure, relevant training and experience, current competence, and practitioner health status to determine the qualification and competence of the medical staff (Joint Commission on the Accreditation of Health Care Organizations, 1994). The Health Plan Employer Data and Information Set (HEDIS 2.0) reports on general consumer satisfaction with physician accessibility and interactions, physician turnover, and board certification status (National Committee for Quality Assurance, 1995). In some cases, individual health plan bylaws require medical and other staff to provide information on actions taken against a licensee or privileges and malpractice judgments or settlements. Additionally, "economic credentialing" assesses practice patterns that may or may not fit within the providers or payers organizational philosophy and market niche (Taber and King, 1994).

A great deal of attention has focused on the development of quality indicators and accreditation standards that may be used by payers, buyers, or consumers of health care services. One study found that experts disagree on what should be included in a health plan report, that the measures used may

not reflect quality, and that consumers had little input to report development (General Accounting Office, 1994). There has been limited discussion of the development and use of quality indicators that could allow consumers to discriminate in the selection of a physician or other health care practitioner from the range of choices available under managed care plans.

CHALLENGES FOR THE 21ST CENTURY

For broader public-private regulatory coordination and streamlining, private facility regulation requirements for practitioners will have to be viewed against those required by the state. For example, demonstrated continuing competency required for facility accreditation may be more rigorous than the continuing education required by state professional boards. In this case, state boards could “deem” — after reviewing the standards against public protection mandates — that private facility accreditation is sufficient for satisfying some individual provider continuing education or competency requirements. Both state regulators and private accreditors will be pressured to standardize these public-private relationships across the states.

Consumers will expect health plan report cards and accreditation reports to be made public and expect public input to the development of the standards. In particular, producers of health plan report cards will be pressured to provide a broader range of practitioner information (e.g. — discipline, malpractice settlements and awards) in addition to the patient satisfaction and board certification measures now provided. The complex issue of institutional peer review processes will have to be evaluated: Are they conducted in too much isolation and are the outcomes reported in a timely manner so as to be useful to boards? Generally, broader reporting to appropriate bodies of discipline actions taken by hospitals and health plans against practitioners will be expected.

The Federal Government

The most far-reaching action of the federal government related to state regulation of the health professions was the affirmation by the U.S. Supreme Court of the constitutional right of state licensing boards to require a specific educational credential in the late 19th century (*Dent v. West Virginia*, 1889). Since this ruling, occupational regulation is a “states’ right” but the federal government has contributed to the shape of health professional regulation through its reimbursement and other policies in Medicare and Medicaid; research on regulation’s effects on health care cost, access and quality; practitioner data collection; education funding; and other initiatives.

The federal government, as a financier and provider of care through Medicare, Medicaid, the Indian Health Services and other programs, is both a direct and indirect regulator of practitioners. As described above, any reimbursement for services directly affects how, and by whom, services are delivered. One example of regulation by federal reimbursement lies in mandates for states to license nursing home administrators, and to regulate nurse aides as a condition for Medicare and Medicaid reimbursement. These mandates were intended as partial solutions to scandals within the nursing home industry.

Federal studies of licensure sponsored by the U.S. Department of Labor in the 1960s focused on licensure's impact on workforce availability, and the cost and quality of services (Holen, 1965; Shimberg, Esser and Kruger, 1972). The principal findings challenged the wisdom that occupational regulation results in higher service quality and benefits consumers beyond the increased cost that licensure causes. These reports recommended that regulation should carefully evaluate the need for new licensed occupations, assure the continuing competence of licensees and greater equity in the discipline of licensed practitioners, improve public representation on licensing boards, remove artificial barriers to interstate mobility, and remove the control of educational functions from boards. (Shimberg, Esser and Kruger, 1972).

Other federal research initiatives affecting professional regulation include the establishment of the National Practitioner Data Bank in 1987 to collect malpractice judgments or settlements, and disciplinary actions taken by state licensing boards and hospitals, and studies by the Office of the Inspector General of the Department of Health and Human Services (Office of the Inspector General, 1995) about hospital reporting to the Data Bank. More recently, the Agency for Health Care Policy and Research has developed and disseminated clinical practice guidelines addressing the treatment of common conditions that carry high economic price tags (Youngs and Wingerson, 1995).

The most sweeping federal health professions regulatory proposal came during President Clinton's health care reform debates. His plan would have mandated a federal override of state regulations where the practice of any class of health professional was restricted beyond what is justified by the skills and training of these professions (H.R. 1200, 1993). Even though vague and lacking enforcement authority, any proposals for such "federalization" of state regulation has been opposed by many major professional groups (Winn, 1995).

Finally, federal grants and other financial assistance provide significant support for health professional education and training. The federal government has been criticized for supporting education and training priorities that do not address public health needs (Budetti, 1993). In medical education alone, some \$6 billion per year supports graduate residency training for many specialist physicians, despite the oversupply of specialists (Weiner, 1994). Such funding also contributes to the perpetuation of traditional professional turf boundaries.

CHALLENGES FOR THE 21ST CENTURY

Given the complexity and diversity of the federal impact on health professions regulation, it will be challenging to ensure that these policies are consistent with, and supportive of, state efforts to streamline professional regulation and to eliminate regulatory barriers to the provision of cost-effective, accessible, quality health care. Concerns over excessive or intrusive federal regulation into states' and private market affairs will effectively eliminate the possibility of "federalized" health professions regulation. It will be more important for federal agencies — through reimbursement and facility licensing, education funding and other efforts — to facilitate the development, dissemination, and evaluation of uniform (non-federal) entry-to-practice standards, model scopes of practice, and innovations in education and workplace design.

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David Swankin, JD is president of the Citizen Advocacy Center, a training, research and support network for public members of health care regulatory and governing boards. Swankin is also the president of the Regulatory Alternatives Development Corporation, and a partner in the law firm of Swankin and Turner. Swankin is an attorney specializing in regulatory and administrative law. He has a broad background in both government and public interest advocacy. Previously, he served as director of the Bureau of Labor Standards and deputy assistant secretary, U.S. Department of Labor. He served as the first executive director of the White House Office of Consumer Affairs in the mid-1960s. Swankin was a member of the original National Advisory Council to the Consumer Product Safety Commission, has served on the faculty of the University of Southern California (Washington, D.C. campus), and is a former member of the board of directors of the American Society for Testing and Materials.

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Pew Health Professions Commission

The Pew Health Professions Commission, established in the spring of 1989 and administered by the University of California at San Francisco, Center for the Health Professions, is charged with assisting health professionals, workforce policy makers and educational institutions in responding to the challenges of the changing health care system.

The Pew Health Professions Commission and the UCSF Center for the Health Professions are supported by grants from the Pew Charitable Trusts. The opinions expressed in this report are those of the authors and do not necessarily reflect the views of the Pew Charitable Trusts.

Pew Health Professions Commission

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